DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 7

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 18, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.272

7. FEDERAL BUDGET IMPACT: 20,089,509 "P+I" HCFA 6/8/01
a. FFY 00 $ ~~16,116,782~~
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Section 2, Pages 1a, 1b, 1c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Section 2, Pages 1a, 1b, 1c

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Supplemental Payments

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
not required

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
H. David Bruton, MD

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Office of the Secretary
Department of Health & Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 28, 2000

18. DATE APPROVED:
May 24, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 18, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

Instructions on Back

MEDICAL ASSISTANCE
STATE: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.a.1. Supplemental Payments for Outpatient Hospital Services

Hospitals licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50 percent of their Medicaid inpatient discharges for the fiscal years ending September 30, 2000 and thereafter shall be eligible for a lump sum payment for the period from September 18, 2000 through September 30, 2000, and lump sum payments for subsequent fiscal years calculated and paid no less frequently than annually and no more frequently than quarterly in amounts or percentages determined by the Director of the Division of Medical Assistance for periods preceding or following the payment date subject to the following provisions:

(1) To ensure that the payments authorized by this Paragraph do not exceed the applicable upper such payments (when added to Medicaid payments received or to be received for these services) shall not exceed for the 12 month period ending September 30 of the year for which payments are made the applicable percentage of:

(i) the reasonable cost of outpatient hospital Medicaid services; plus

(ii) the reasonable direct and indirect costs attributable to outpatient Medicaid services of operating Medicare approved graduate medical education programs.

A. The phrase "applicable percentage" refers to the upper limit as a percentage of reasonable costs established by 42 C.F.R. 447.321 for different categories of hospitals.

B. Reasonable costs shall be ascertained in accordance with the provisions of the Medicare Provider Reimbursement Manual as defined on page 9 Paragraph (b) of Attachment 4.19-A of this state plan.

C. The phrase "Medicaid payments received or to be received for these services" shall exclude all Medicaid disproportionate share hospital payments received or to be received.

(2) Qualified public hospitals shall receive a payment under this Paragraph in amounts (including the expenditures described in Subparagraph A (iii) below) not to exceed the applicable percentage of each hospital's Medicaid costs for the twelve month period ending September 30 of the fiscal year for which such payments are made, less any Medicaid payments received or to be received for these services.

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A. A qualified public hospital is a hospital that meets the other requirements of this Paragraph and:

(i) was owned or operated by a State (or by an instrumentality or a unit of government within a State) during the period for which payments are made; and

(ii) verified its status as a public hospital by certifying State, local, hospital district or authority government control on the most recent version of Form HCFA-1514 filed with the Health Care Financing Administration, U.S. Department of Health and Human Services at least 30 days prior to the date of any such payment that remains valid as of the date of any such payment; and

(iii) files with the Division on or before 10 working days prior to the date of any such payment by use of a form prescribed by the Division certification of expenditures eligible for FFP as described in 42 C.F.R. 433.51(b). This provision shall not apply to qualified public hospitals that are also designated by North Carolina as Critical Access Hospitals pursuant to 42 USC 1395i-4.

(3) Hospitals licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50 percent of their Medicaid inpatient discharges for the fiscal years ending September 30, 2000 and thereafter that are not qualified public hospitals as defined in this Paragraph shall be entitled to lump sum payments in amounts that do not exceed the applicable percentage of each hospital's Medicaid costs (calculated in accordance with Subparagraph (1)) for the twelve month period ending September 30 of the fiscal year for which such payments are made less any Medicaid payments received or to be received for these services.

(4) Payments authorized by this Paragraph shall be made solely on the basis of an estimate of costs incurred and payments received for Medicaid outpatient services for the period for which payments are made. The Director of the Division of Medical Assistance shall determine the amount of the estimated payments to be made by analysis of costs incurred and payments received for Medicaid services as reported on the most recent cost reports filed before the Director's determination is made and supplemented by additional financial information available to the Director when the estimated payments are calculated if and to the extent that the Director concludes that the additional financial information is reliable and relevant.

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(5) To ensure that estimated payments pursuant to this Paragraph do not exceed the aggregate upper limits to such payments established by applicable federal law and regulation (42 C.F.R. 447.321), such payments shall be cost settled within 12 months of receipt of the completed and audited Medicare/Medicaid cost reports for the period for which payments are made. There shall be a separate aggregate cost settlement pool for qualified hospitals that are owned or operated by the State, for qualified public hospitals that are owned or operated by an instrumentality or unit of government within a state and for hospitals qualified for payment under this Paragraph that are not qualified public hospitals. If aggregate payments to the hospitals in any of the three cost settlement pools exceed the aggregate upper limit for the hospitals in that pool, hospitals in that pool that receive payments in excess of unreimbursed reasonable costs as defined in this Paragraph shall promptly refund their proportionate share of any aggregate payments to the hospitals in that pool in excess of the aggregate upper limit of the hospitals in that pool. No additional payment shall be made in connection with the cost settlement.

(6) The payments authorized by this Paragraph shall be effective in accordance with G.S. 108A-55(c).

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2.a.1. Supplemental Payments for Outpatient Hospital Services

Hospitals licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50 percent of their Medicaid inpatient discharges for the 12-month period ending September 30, 2000 shall be entitled to an additional payment for outpatient hospital services in an amount determined by the Director of the Division of Medical Assistance, subject to the following provisions:

(1) To ensure that the payments authorized by this Paragraph for qualified public hospitals that qualify under the criteria in Subparagraph A., below do not exceed the upper limits established by 42 CFR 447.321, the maximum payments authorized for qualified public hospitals shall be determined for all such qualified public hospitals for the 12 month period ending September 30, 2000 by calculating the "Outpatient Medicaid Deficit" for each hospital. The Outpatient Medicaid Deficit shall be calculated by ascertaining the reasonable cost of outpatient hospital Medicaid services; plus the reasonable direct and indirect costs attributable to outpatient Medicaid services of operating Medicare approved graduate medical education programs; less Medicaid payments received or to be received for these services. For purposes of this Subparagraph:

A. A qualified public hospital is a hospital that meets the other requirements of this Paragraph and:

(i) was owned or operated by a State (or by an instrumentality or a unit of government within a State) from September 18, 2000 through and including September 30, 2000; and

(ii) verified its status as a public hospital by certifying State, local, hospital district or authority government control on the most recent version of Form HCFA-1514 filed with the Health Care Financing Administration, U.S. Department of Health and Human Services on or before September 18, 2000; and

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(iii) files with the Division on or before September 18, 2000 by use of a form prescribed by the Division, a certificate of public expenditures to support a portion of the non-federal share of the payment it will receive pursuant to this Paragraph. This provision shall not apply to qualified public hospitals that are also designated by North Carolina as Critical Access Hospitals pursuant to 42 USC 1395i-4.

B. Reasonable costs shall be ascertained in accordance with the provisions of the Medicare Provider Reimbursement Manual as defined on page 9 Paragraph (b) of Attachment 4.19-A of this Plan.

C. The phrase "Medicaid payments received or to be received for these services" shall exclude all Medicaid disproportionate share hospital payments received or to be received.

(2) Qualified public hospitals shall receive a payment under this Paragraph in an amount (including the public expenditures certified to the Division by each hospital for a portion of the non-federal share) not to exceed each hospital's Outpatient Medicaid Deficit.

(3) Hospitals licensed by the State of North Carolina and reimbursed under the DRG methodology for more than 50% of their Medicaid inpatient discharges for the 12-months ending September 30, 2000 that are not qualified public hospitals as defined in this Paragraph shall be entitled to an additional payment under this Paragraph for their Outpatient Medicaid Deficit calculated in accordance with Subparagraph (1) in an amount not to exceed 61.1132148 percent of their Outpatient Medicaid Deficit.

(4) Payments authorized by this Paragraph shall be made solely on the basis of an estimate of costs incurred and payments received for Medicaid outpatient services during the twelve months ending September 30, 2000. The Director of the Division of Medical Assistance shall determine the amount of the estimated payments to be made by analysis of costs incurred and payments received for Medicaid services as reported on cost reports for the fiscal year ending in 1999 filed before September 18, 2000 and supplemented by additional financial information available to the Director when the estimated payments are calculated if and to the extent that the Director concludes that the additional financial information is reliable and relevant.